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Ms Bec Cody MLA (Chair), Mrs Vicki Dunne MLA (Deputy Chair)
Ms Caroline Le Couteur MLA

Submission Cover Sheet

Inquiry into Maternity Services in the ACT

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PERINATAL DEPRESSION
and the TRANSITION TO PARENTHOOD

Dr Joan Garvan

There is little Australian research on the Transition to Parenthood (TtoP), however, a finding from the Australian Institute of Health and Welfare[1] stated that in 2010 - 1 in 5 - or 20% of mothers with children aged 24 months or less have been diagnosed with depression. More than half of these mothers reported that their depression was perinatal, the depression was diagnosed from pregnancy until the child's first birthday, and the rates of anxiety went much higher. The response in Australia to Perinatal Depression has been highly medicalized while the literature on depression most often emphasises the critical role of partner and social support in the early years after the birth. The related health services are patchy with an emphasis on the health and wellbeing of infants and children. The Post and Antenatal Depression agency in Victoria (among others) needs to fund raise so as to maintain and expand their services http://www.panda.org.au/

There is currently a drive to bring more women into the workforce, while countries across the globe have brought in policies to promote the fertility rate. The research on the Transition to Parenthood, however, shows that attempts by many couples to achieve a form of gender equal family after the birth of an infant are being held back.[2] Movements towards equity have reached a new 'high water mark' in this regard and these trends within families are importantly influenced by an institutional reluctance to change. Women and their families are paying the cost through poor health and wellbeing outcomes.

Our institutional framework has failed to keep pace with social change and there is a significant gap between our expectations and experiences after the birth of an infant. This is an important factor that is contributing to high rates of depression and anxiety. While the response remains heavily medicalized and the related health services primarily concerned with infant/child outcomes parents will continue to struggle with significant issues related to the Transition to Parenthood.

Changing Family Dynamics

The Transition to Parenthood is a term often used by researchers on the family or by social psychologists to describe the adjustments that both men and women

[1] AIHW, 2010, *Perinatal depression Data from the 2010 Australian National Infant Feeding Survey, Information Paper*. AIHW, Canberra

[2] 'logic of gendered choice' Singley and Hynes 2005, 395

negotiate when they become first-time parents. These adjustments are said to begin during the nine months before the birth and carry on into the first two years afterwards.[3] The indicators generally fall under the categories of:

changes to identity;
changes to life course;
changes to relationships (including partner, friends and family)
and negotiating more housework.

A further and central element in this transition is in the developing relationship between the mother and her infant/child, the interpersonal dimension of care.

A contributing factor to these issues raised by the TtoP, not often referenced in the relevant Australian research, but evident in the programs**,** is the changing dynamics between couples after the birth. There is an emphasis on couples working together in programs such as Baby makes 3, Bringing Baby Home, and in information provided by the Parenting and Infant Research Institute http://www.piri.org.au/BUPparentAndBabyWellbeingProgram.php

An important element of the aforementioned gap between the expectations and the experience of women after the birth, frequently unexplored in the related literature, is the unstated and gendered expectations that accompany the birth. Most of the sixteen women that I interviewed for my doctoral thesis[4] became full-time carers - to be with - and look after their infants and toddlers – rather than to become a housewife.

Many women know today about the importance of the early years for infants and children. Many feel pulled between a desire to stimulate and engage with their babies/toddlers AND the practicalities of care (the washing, the cooking, the cleaning and more). These tensions caused anxiety to dismay among 40% of interviewees for my research. Though many couples are attempting to work this out there was evidence of conflict for some between an expectation that the women would also take on primary responsibility for the housework (through the week and on weekends). One of the women I interviewed said that after the early rise, we all know about, and having cooked the dinner there was generally a stand-off between herself and her husband about the dishes, with the expectation that she would be the one to clean up. This is something that may sound petty but it was a ritual that caused dismay in this case and in others.

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[3] Cowan and Cowan 1998, 175

[4] Garvan, Joan. 2010. *Maternal Ambivalence in contemporary Australia: Navigating equity and care*, PhD Thesis, Australian National University.

Findings from Research on the Transition to Parenthood

An impetus for the study of issues related to TtoP has been gender equity within the household but further to this Cowan and Cowan stated that they were concerned to strengthen the couple relationship and support children. Herein is a key tension between the requirements of care and equity. The TtoP most often occurs within families, and the couple relationship is central to family dynamics. Couples negotiate issues related to equity and care within a social and economic system that has been built on an assumption of the male breadwinner model. These tensions and dynamics are often dramatically played out through dispositions that are socially and culturally constructed.

In numerous studies on the TtoP - the birth of a child was found to be 'a critical life stage' that is often experienced as overwhelming.[5] This period was also said to be followed by a trend towards 'traditional' gender roles, however, the use of traditional as an analytic category in the relevant literature is questionable. Women are most often doing more housework than men, even if they have children and are working full time, but this is generally followed by raised levels of stress and/or depression; an unfulfilled expectation that both the care and the housework would have been shared.

This was a finding that was replicated in a review of fifty-nine studies on Family Therapy and the TtoP by Glade, Bean and Vera (2005). Nystrom and Ohrling's (2004, 328) also analysed thirty-three studies by nurses and argued that there was an association between a maternal sense of losing control, depression and social/marital supports, while Cowan and Cowan (1998) found links between a failed expectation of gender equity and depression. Golberg and Perry-Jenkins (2004, 233) linked this outcome to an gap between the expectations and the experience, and an ambivalence between a right to express discontent and the status quo. Never-the-less the researchers often went on to reflect on a need to review expectations and/or strengthen the couple relationship by way of overcoming these shortfalls, falling back onto the individual, rather than structural change; for more on this research see the accompanying bibliography.

There was a decline in the postnatal health and well-being for approximately one-third of the women interviewed for my thesis, a figure that is consistent with findings from research on the TtoP (McHale et al. 2004).

[5] See: Bibliography – Depression and the Transition to Parenthood

Social & Cultural factors contributing to Anxiety & Perinatal Depression

A significant 10 to15 per cent of women in Australia have been documented as suffering with ante- and/or postnatal depression (Williamson and McCutcheon 2004; beyondblue 2008). The Australian Perinatal Mental Health National Action Plan (2008) and Buultjens and Liamputtong (2007) identified the social context of birth as an important contributing factor, however, research has most often continued to focus on the pathological rather than the contributing social influences (Nicholson 1998; Ussher 2006). Buultjens and Liamputtong extended this emphasis to the cultural and political context of birth, including unrealistic expectations and stigmatization as important contributing factors to depression.

The spectrum for the experience of depression after the birth ranges from psychosis to mild anxiety. In an environment that shies away from the social-cultural context of health, gender and depression are held together through a continuing medicalization that in turn individualizes the effect (Hasler 2009). The biomedical model of health that informs practice in Australia is based on a physiological understanding that is treated with medication and/or talking cures. The condition is pathologized whereby the experience is understood as a product of a biological deficiency manifested by a chemical imbalance (Hasler 2009, 49). Hasler argues that PND is similar to other depressive episodes other than the fact that there is a baby that requires care and that this should be the main focus of research. She continues:

> Although depression is experienced as a personal problem, sociologists generally agree that it can also be understood as a type of social distress that originates in the larger social problems of inequity, alienation, and powerlessness that affect certain groups of people (Mirowsky and Ross 1989). (Hasler 2009, 50).

Hasler's qualitative study of twenty women who experienced PND in Australia found that seventy five per cent of her participants believed that psychosocial factors were of primary concern, rather than the biomedical. These issues are indicative of a serious health problem and yet a continuing emphasis on pathology contributes to a conspiracy of silence around the effects of motherhood on maternal health (le Blanc 1999). Drawing from interviews with focus groups and individuals, Le Blanc detailed evidence of maternal fatigue, stress, depression, isolation, frustration, anger and guilt. Furthermore, Jane Ussher argues that ante- and postnatal depression may well be an expression of rage that women turn on themselves in response to a continuing and gendered structuring of care that effectively seals off change for many (Ussher 2006). A featured article by Jane Ussher in the journal

Feminism and Psychology brought forth a considered response. The initial paper: *Are we medicalizing women's misery?* and follow-up articles that are listed in the attached Bibliography.[6]

The social context of birth and early parenting clearly have a significant effect over the experience of first-time parents, an emphasis also recognized in a Swiss study by Perron, Burgin et al. (2005). Because the family is an embedded unit within the larger social system, social factors such as a small apartment and/or low income have a serious effect on parental feelings and behaviour.

A major European study drawing from both quantitative and qualitative findings from eight countries on work–family boundaries concluded that 'gender shapes parenthood and makes motherhood different from fatherhood both in everyday family life and in workplaces (Lewis and Smithson 2006, 13). This is a finding that is echoed in the assertion by McHale et al. (2004, 725) that 'mothers, but not fathers, see themselves as ultimately responsible for child care'. The 'transition to parenthood' was identified by Lewis and Smithson as critical in attempts to achieve gender equal outcomes. A claim substantiated by Australian research by Baxter, Hewitt and Haynes (2008) in relation to the development of a gender wage gap, labelled 'the motherhood wage penalty'; another proposition that is substantiated by multiple studies.

In *Motherhood and Postnatal Depression*[7], Carolyn Westall and Pranee Liamputtong based their findings on in-depth interviews with 33 women from Melbourne who resolved PND and 18 of their partners. They spoke of a need for a **'biopsychosocial model'** that recognised diverse factors that spanned these three realms. Psychosocial factors included: relationship difficulties, poverty, social class, past abuse and unrealistic expectations amongst others. Westall and Liamputtong identified social support[8] as a most important variable and recognised the influence of a things such as: a traumatic birth, loss of control, stigma, isolation, lack of information and adjustment to motherhood. The authors also referenced the World Health Organisation's

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[6] Stoppard, Janet. 2010. Moving towards an understanding of women's depression, *SPECIAL FEATURE – Feminism & Psychology*. Vol. 20, no. 2; Grace, Victoria. 2010. The desiring, gendered speaking being: Going a bit further with Ussher on women and depression. *Feminism & Psychology*, Vol. 20 (2); Liebert, Rachel, III Feminist psychology, hormones and the raging politics of medicalization. *Feminism & Psychology*. Vol. 20 (2); THESE ARE ACCOMPANIED BY EARLIER ARTICLES IN THE SAME PUBLICATION AND LISTED IN THE BIBLIOGRAPHY: Ussher, J. 2003. I *Biology as Destiny: The legacy of Victorian Gynaecology in the 21st Century*; LaFrance, M. 2006. *Constructing a non-depressed self: Women's accounts of recovery from depression*; Nicholson, P. 2004. I *Biological politics: Challenging man-made science*.

[7] See: http://books.google.com.au/books/about/Motherhood_and_Postnatal_Depression.html?id=rSijTIwvg24C&redir_esc=y

[8] Other studies highlighting social support include: Tantano Beck (2008); Xie et al. (2010); Manuel et al. (2012)

work on Gender and Health that identified single parenthood, poverty, live stressors, the 'double shift', employment status and lower wages, and the psychological cost of being a carer as important contributing factors to PND. Westall, who had been a nurse and had experience PND, also set out a range of possible responses.

Childcare-Housework Distinction and the Egalitarian Family Form

A distinction between childcare and housework is useful. The quantity of housework expands during this period, with many of the tasks related to the care of the infant/child. The negotiation of this work coupled with the prime responsibility for care contributes to maternal stress. The women interviewed for my thesis were not taking time out from the workforce to attend to the housework and conform to traditional roles, but because they are concerned with the health and well-being of their infants. There has often been a reliance on 'traditional' to hold together an array of characteristics that have been associated with gendered roles, whereas in this period of change it is critical to break down and examine the constitute parts.

The vast majority of couples are seeking to establish a form of gender equity within their families after the birth. This trend is evident in the results of two waves of the National Survey of Families and Households in the USA cited by Kaufman (2000, 135) whereby 76 per cent of women held an egalitarian attitude to family formation.[9] This trend towards egalitarianism is, however, implied in most of the referenced studies by the largest proportion of participants ascribing to equal or egalitarian arrangements within their families. The study by McHale et al. (2004) is an intervention in a field of 'co-parenting studies', and while they were concerned with the effect of the infant on family dynamics, they note a link between a failed expectation of gender equity for women and marital dissatisfaction (also noted by Glade, Bean and Vira 2005, 715). Cowdery and Knudson-Martin (2005, 343) found evidence of inequitable gender outcomes with couples who had children under five years of age 'despite ideals to the contrary' which they said were perpetuated through an 'idealization of motherhood' that became a 'self-perpetuating cycle'.

Some Australian papers available online that I will feature here are firstly:

Parker. 2011. *Supporting couples across the transition to parenthood*.

[9] Gender roles, housework and employment were explored from U.S. figures by Sanchez and Thomson (1997).

This relatively recent paper scans research on the TtoP. There are a number of limitations with this paper firstly it doesn't mention the lack of Australian research and it references few of the studies that I came across. The criticism that research on the TtoP is reliant on small studies is contestable as is the proposition that the research is generally carried out during pregnancy. Never-the-less the paper canvases a range of relevant topics and references a couple of papers that have carried out a mega-anlysis; one by Twenge et al. on marital satisfaction and another by Pinquart on the effectiveness of programs. The paper furthermore highlights the need for further research.

Johnson, Schmied et al. 2012. *Measuring perinatal mental health risk*;

This paper compares and contrasts current methods of psychosocial assessment. It sets out the criteria, reliability and validity of six tools and discusses the pros and cons. It is interesting that all of these methods received an overall rating of – not recommended. A suggested limitation was sample sizes fewer than 1,000 women. Factors such as family violence, partner support, accommodation, life stresses, and budgeting where amongst the criteria though interestingly there was no reference to issues arising from the birth, career options or communication between partner, friends or family where identified. It would be good to know your thoughts on this paper's findings.

Leigh and Milgrom. 2008. *Risk factors for antenatal depression, postnatal depression and parenting stress*;

This is an older study but it sets out the risk factors and the predictors. Leigh and Milgrom identify 'Antenatal depression' as a predictor and 'parenting stress', including problems in the mother-infant dyad, as mediating factors.

An Australian doctoral thesis relevant to PND, is the earlier mentioned, Jane Hasler's *'No Bloody Wonder' – Exposing the relationship between postnatal depression (PND) and the gender order*.

Liana Leach. 2009. *Gender differences in depression and anxiety across the adult lifespan: the role of psychosocial mediators* – an Australian thesis see: https://digitalcollections.anu.edu.au/bitstream/1885/49398/2/02whole.pdf or a shorter journal article listed in the bibliography.[10] Leach looked at psychosocial risk factors at three life stages: 20 to 24; 40 to 44; and 60 to 64. She found that women are twice as likely to experience depression and anxiety disorders then are men.

[10] Leach, Liana, Helen Christensen et al. 2008. *Gender differences in depression and anxiety across the adult lifespan: the role of psychosocial mediators*. Social Psychiatry Psychiatric Epidemiology. 43 pp. 983-998.

In 2012 Jodie Anne Batten, completed a Master of Arts in New Zealand titled: *Context matters: Women's experiences of depression and of seeking professional help*. Drawing from the stories of 7 women Batten explored how they constructed their experience of depression and went on to place these within the broader socio-cultural environment. The author saw a progression from an understanding of gendered constraint to a biomedical model that centered on anti-depressant medications that she believed effectively silenced and decontextualized their voices see:
http://mro.massey.ac.nz/handle/10179/3688

Stephen Mattey, 2010, from the School of Psychology at the University of Sydney raises questions about the scales being used to identify depression, which he said, may be overstating the numbers.

There are two further studies conducted by nurses in the USA, Cheryl Beck Tantano, *State of the Science on Postpartum Depression: what nurse researchers have contributed Parts 1 & 2*. The author brings together an extensive body of nursing research while referencing a notable proportion of cross-cultural studies. In this first paper she surveys international research (across 9 countries) by nurses but also studies based in Taiwan, Turkey, Sweden and the USA and in the second paper, amongst other national studies she references work from Australia. Risk factors identified by nurses included social support, low self esteem, life stress, fatigue and prenatal depression. Tantano reviews measuring instruments and screening, she surveys interventions and highlights clinical implications which includes the proposition that postpartum depression is a universal phenomenon and jut just limited to industrialized western societies.

The Australian Institute of Family Studies released a report (available online) titled: *Families, life events and family service delivery: a literature review* in May 2012. Chapter 4 focuses on the transition to parenthood as a case study of events experienced by families, and chapter 5 looks at issues in service delivery. The literature and issues cited on the TtoP, I believe are inadequate, and the chapter on service delivery is scanty in bringing together theory with practice. There is a recognition of issues raised by the TtoP with later reference to the new Family Relationship Centers but no mention of the related health services. An emphasis of chapter 5 is on the need for better communication about and between service providers. The chapter cites the 'no wrong door' notion that clients should not be the ones to shoulder the burden of having to match their need with the correct service and sets down this as a continuing challenge for the services while there is little reference to how this might be overcome.

Concluding comments

Cultural traditions and beliefs about what it means to be a mother are in flux and mixed up with interpersonal dynamics between the woman-as-mother and her infant. In this context of change becoming a mother is generally a profound and life-changing experience of important social, cultural and personal consequence. Gender equity calls for continuing institutional change along with a rethinking of educational systems that rely on someone being around for the three o'clock pickup and a twelve week holiday program.

The Midwifery and/or Family and Child Health services could assist individuals or couples manage these contemporary pressures. The issues associated with the 'transition to parenthood' such as changes to the sense of self, changes to relationships, changes to the life course, negotiating more housework, and – finding a line between self and baby – are topics that could be more widely integrated within these related health programs if they aren't there already. I understand that these services are being continually revised and updated and that there are moves towards standardization, however, while there continues to be an emphasis on a biomedical model of health, and infant/child outcomes, to the exclusion of this wider social and cultural context of change, an opportunity is lost.

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*** indicates the article is available online – do a search on title*

NOTE: I have labelled the article according to the national context. You will see that there are a number of Australia papers. Most of these are concerned with maternal depression and reference issues related to the need for support that resurfaces throughout the early years after the birth and yet most often do not cite the Transition to Parenthood as a mediating factor; this may be an effect of disciplinary boundaries.

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